Behavioral Health and Primary Care Integration: Models and Strategies

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National Council for Community Behavioral Healthcare
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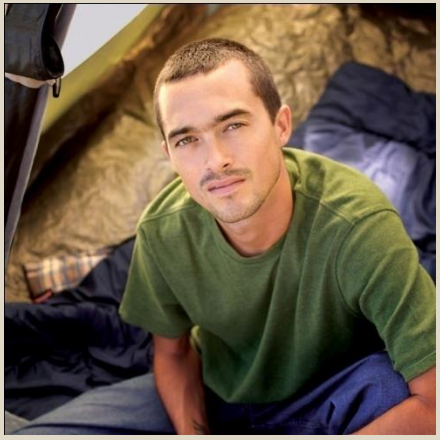


Overview

- A changing landscape for behavioral health
- Medicaid expansion and the influx of new consumers
- New approaches to organizing care
- Demonstrating value and accountability: Are you ready?

Delivery System Redesign – Health Homes (Medical Homes) (Integration) – Models of Integration

Healthcare Models of the Future

- Coverage expansions are ONLY sustainable with delivery system reform
  - Collaborative Care
  - Patient Centered Healthcare Homes
  - Accountable Care Organizations

- Accountability and quality improvement are hallmarks of the new healthcare ecosystem

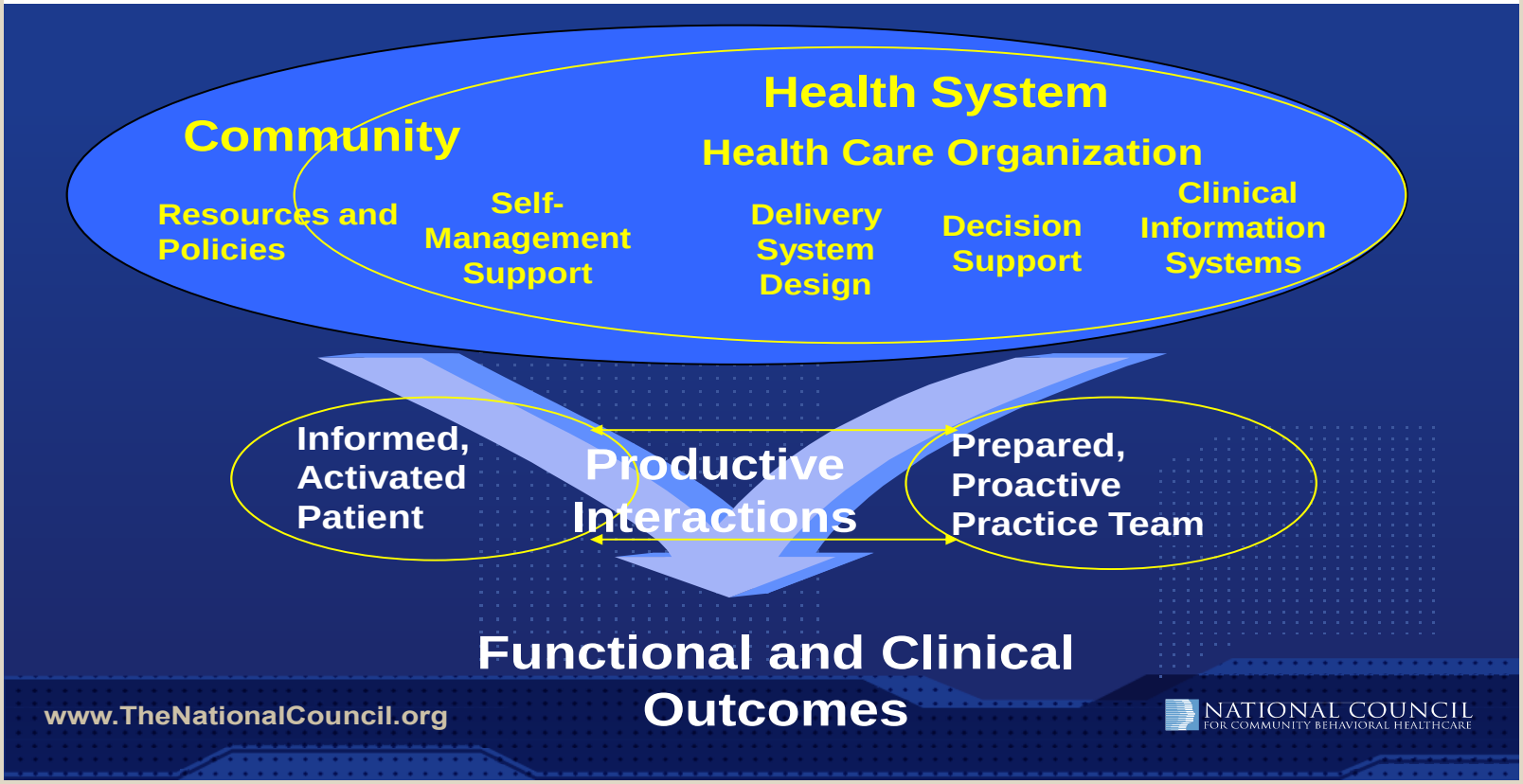
Levels of Integration

Function	Minimal Collaboration	Basic Collaboration from a Distance	Basic Collaboration On-Site	Close Collaboration/ Partly Integrated	Fully Integrated/Merged
THE CONSUMER and STAFF PERSPECTIVE/EXPERIENCE					
Access	Two front doors; consumers go to separate sites and organizations for services	Two front doors; cross system conversations on individual cases with signed releases of information	Separate reception, but accessible at same site; easier collaboration at time of service	Same reception; some joint service provided with two providers with some overlap	One reception area where appointments are scheduled; usually one health record, one visit to address all needs; integrated provider model
Services	Separate and distinct services and treatment plans; two physicians prescribing	Separate and distinct services with occasional sharing of treatment plans for Q4 consumers	Two physicians prescribing with consultation; two treatment plans but routine sharing on individual plans, probably in all quadrants;	Q1 and Q3 one physician prescribing, with consultation; Q2 & 4 two physicians prescribing some treatment plan integration, but not consistently with all consumers	One treatment plan with all consumers, one site for all services; ongoing consultation and involvement in services; one physician prescribing for Q1, 2, 3, and some 4; two physicians for some Q4: one set of lab work
Funding	Separate systems and funding sources, no sharing of resources	Separate funding systems; both may contribute to one project	Separate funding, but sharing of some on-site expenses	Separate funding with shared on-site expenses, shared staffing costs and infrastructure	Integrated funding, with resources shared across needs; maximization of billing and support staff; potential new flexibility
Governance	Separate systems with little of no collaboration; consumer is left to navigate the chasm	Two governing Boards; line staff work together on individual cases	Two governing Boards with Executive Director collaboration on services for groups of consumers, probably Q4	Two governing Boards that meet together periodically to discuss mutual issues	One Board with equal representation from each partner
EBP	Individual EBP's implemented in each system;	Two providers, some sharing of information but responsibility for care cited in one clinic or the other	Some sharing of EBP's around high utilizers (Q4) ; some sharing of knowledge across disciplines	Sharing of EBP's across systems; joint monitoring of health conditions for more quadrants	EBP's like PHQ9; IDDT, diabetes management; cardiac care provider across populations in all quadrants
Data	Separate systems, often paper based, little if any sharing of data	Separate data sets, some discussion with each other of what data shares	Separate data sets; some collaboration on individual cases	Separate data sets, some collaboration around some individual cases; maybe some aggregate data sharing on population groups	Fully integrated, (electronic) health record with information available to all practitioners on need to know basis; data collection from one source

Selecting a Conceptual Model

- Wagner Chronic Care
- Four Quadrant Model

Wagner Chronic Care Model



The Four Quadrant Clinical Integration Model

*PCP-based BH provider might work for the PCP organization, a specialty BH provider, or as an individual practitioner, is competent in both MH and SA assessment and treatment

Quadrant I – Low PH Low MH

- **Quadrant I: Low BH/Low PH**
  - PCP (with standard screening tools and BH practice guidelines)
  - PCP- Based BH
- Interventions
  - Screening for BH Issues (Annually)
  - Age Specific Prevention Activities
  - Psychiatric Consultation

Quadrant II – High BH Low PH

- **Quadrant II – High BH/Low PH**
  - BH Case Manager w/responsibility for coordination w/PCP
  - PCP with tools
  - Specialty BH
  - Residential BH
  - Crisis/ER
  - Behavioral Health IP
  - Other Community Supports
- **BH Interventions in Primary Care**
  - **IMPACT Model for Depression**
  - **MacArthur Foundation Model**
  - **Behavioral Health Consultation Model**
  - **Case Manager in PC**
  - **Psychiatric Consultation**
- **PC Interventions CMH**
  - **NASMHPD Measures**
  - **Wellness Programs**
  - **Nurse Practitioner, Physician's Assistant, Physician in BH**

Quadrant III – Low BH High PH

- **Quadrant III – Low BH/High PH**
  - PCP with screening tools
  - Care/Disease Management
  - Specialty Med/Surg
  - PCP based- BH
  - ER
- **Interventions**
  - BH Ancillary to Medical Diagnosis
  - Group Disease Management
  - Psychiatric Consultation In PC
  - MSW in Primary Care
  - BH Registries in PC (Depression, Bipolar)

Quadrant IV – High BH High PH

- **Quadrant IV- High BH/High PH**
  - PCP with screening tools
  - BH Case Manager with Coordination with Care Management and Disease Management
  - Specialty BH/PH
- **Interventions in Primary Care**
  - **Psychiatric Consultation**
  - **MSW in Primary Care**
  - **Case Management**
  - **Care Coordination**
- **Interventions in BH**
  - **Registries for Major PC Issues (Diabetes, COPD, Cardiac Care)**
  - **NASMPD Disease Measures**
  - **NP, PA or Physician in BH**

POTENTIAL CLINICAL MODEL(S) OF INTEGRATION

Models/Strategies – Bi-Directional Integration

Behavioral Health –Disease Specific

- IMPACT
- RWJ
- MacArthur Foundation
- Diamond Project
- Hogg Foundation for Mental Health
- Primary Behavioral Healthcare Integration Grantees

Behavioral Health - Systemic Approaches

- Cherokee Health System
- Washtenaw Community Health Organization
- American Association of Pediatrics - Toolkit
- Collaborative Health Care Association
- Health Navigator Training

Physical Health

- TEAMcare
- Diabetes (American Diabetes Assoc)
- Heart Disease
- Integrated Behavioral Health Project – California – FQHCs Integration
- Maine Health Access Foundation – FQHC/CMHC Partnerships
- Virginia Healthcare Foundation – Pharmacy Management
- PCARE – Care Management

Consumer Involvement

- HARP – Stanford
- Health and Wellness Screening – New Jersey (Peggy Swarbrick)
- Peer Support (Larry Fricks)

Defining the Healthcare Home

Superb Access to Care

Patient Engage-ment in Care

Clinical Infor-mation Systems

Care Coor-dination

Team Care

Patient Feed-back

Publicly Available Infor-mation

Person-Centered Healthcare Home

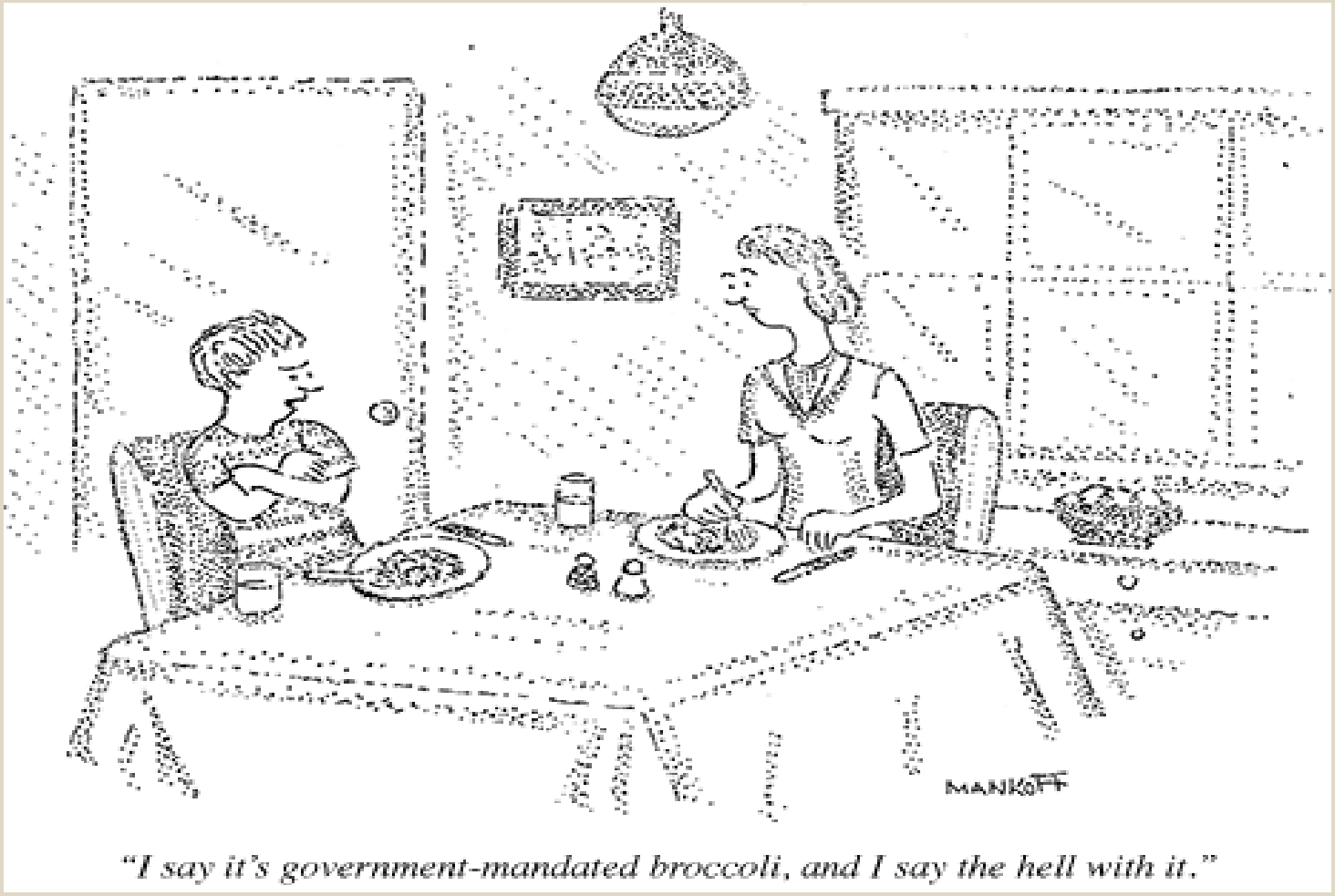
Defining the Healthcare Home

Superb Access to Care

- Everyone has a health home practitioner and team
- Patients can easily make appointments and select the day and time.
- Waiting times are short.
- Email and telephone consultations are offered.
- Off-hour service is available.
- INT 1.03

Care Coordination

- **The Care Coordination Standard:** When I need to see a specialist or get a test, including help for mental health or substance use problems, help me get what I need at your clinic whenever possible and stay involved when I get care in other places.
- Services are supported by electronic health records, registries, and access to lab, x-ray, medical/surgical specialties and hospital care.



"I say it's government-mandated broccoli, and I say the hell with it."

Defining the Healthcare Home

Team Care

- Integrated and coordinated team care depends on a free flow of communication among physicians, nurses, case managers and other health professionals (including BH specialists).
- Duplication of tests and procedures is avoided.

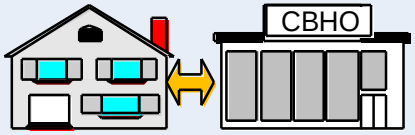
Future of Substance Use Disorders and the Health Home

- **Most** "treatment" funding will come from Medicaid and private health insurance
  - New populations – medical referrals
  - New billing requirements – reporting requirements
  - Emphasis upon outpatient care integrated into "Medical Home"
- Emphasis on "Evidence Based" Practices
- **What is a profitable outpatient model?**

New Paradigm – Primary Care in Behavioral Health Organizations

Funding starting to open up for embedding primary medical care into CBHOs, a critical component of meeting the needs of adults with serious mental illness

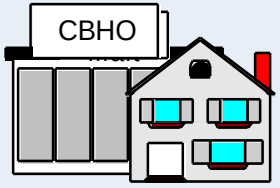
Clinical Design for Adults with Low to Moderate and Youth with Low to High BH Risk and Complexity



Primary Care Clinic with Behavioral Health Clinicians embedded, providing assessment, PCP consultation, care management and direct service

Partnership/ Linkage with Specialty CBHO for persons who need their care stepped up to address increased risk and complexity with ability to step back to Primary Care

Clinical Design for Adults with Moderate to High BH Risk and Complexity



Community Behavioral Healthcare Organization with an **embedded Primary Care Medical Clinic** with ability to address the full range of primary healthcare needs of persons with moderate to high behavioral health risk and complexity

Questions?

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